STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155669	A. BUILDING 01 B. WING	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW TCU	395 WESTFIELD RD NOBLESVILLE, IN46060

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K0000	A Life Safety Code Recertification and a State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/15/11 Facility Number: 011046 Provider Number: 155669 AIM Number: NA Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Riverview TCU was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2 This facility is located on the fourth floor of a fully sprinklered building determined to be of Type I (332) construction. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has a capacity of 25 and had a census of	K0000	The creation and submission of this Plan of Correction does not constitude an admission by this provider of any conclusion set forth in the statement of dificiencies, or of any violation of regulations. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests that this Plan of Corrrection be accepted as written. AddendumWe are sending an addendum to K32 and K34. Due to the non approval of the current Fire Safety Evaluation System (FSES) We have requested an updated survey to meet your request. Therefore we are requesting and extention to the original date to 8/15/11.This provider respectfully requests a Post Survey Review after 8/15/11.If there are any further questions please contact David Woods at 317-770-2870.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	16 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/17/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0032 SS=F	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 Based on observation and interview, the facility failed to ensure 2 of 2 smoke compartments were provided with at least one exit providing a continuous path of travel to an exit discharge. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on observations with the Executive Director during a tour of the facility from 11:30 a.m. to 12:15 p.m. on 06/15/11, the TCU has two emergency exits. One exit is a horizontal exit into the adjacent smoke compartment. The adjacent smoke	K0032	ADDENDUM ON 7/5/2011THIS PLAN OF CORRECTION FOR K 0032 IS BEING AMENDED TO INCLUDE AN UPDATED FIRE SAFETY EVALUATION SYSTEM (FSES). RTM CONSULTANTS INC, HAVE BEEN CONTACTED AND PLAN AN INITIAL VISIT TO RIVERVIEW HOSPITAL ON 7/11/2011 TO DISCUSS THE A PLAN TO COMPLETE AN UPDATED (FSES) SURVEY. RIVERVIEW RESPECTFULLY REQUEST A 30 DAY EXTENTION IN ORDER TO COMPLETE THIS NEW SUREVEY THAT WILL ADDRESS EMERGENCY MOVEMENT ROUTES. TCU NEW DATE OF COMPLETION WOULD BE 8/15/20111.What	08/15/2011

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	compartment has two exit stairwells. The second exit is an exit stairwell that does not connect to an exit discharge directly to the exterior. Based on interview at the time of observation, the Executive Director acknowledged each smoke compartment is not provided with at least one exit discharging directly to the exterior of the building. 3.1-19(b)		corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;This facility does not feel that any patient, staff or visitor had the potential to be negatively affected by this alleged deficient practice because this exit has been assessed by Fire Safety Evaluation System (FSES) which demonstrates equivalent compliance with thier analysis when scoring the total Riverview facility. Please see attached FSES survey and prior Survey conducted by Division of Long Term Care, Indiana State Department of Health regarding K 0032.2. How other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;We do not feel that any patients have the potential to be negatively affected by this alleged deficient practice because we feel that we meet the intent of the law due to the FSES analysis that was completed for this facility. (Safety parameters#10 for Emergency Movement Routes scored deficient (-2) to address this condition)3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Quality Assurance environmental tours will be conducted at least quarterly at which time this exit will be evaluated to be unobstucted.	

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			FSES will be reviewed periodically to document changes in the facility. 4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:This corrective action will be monitored through a monthly checlist by a CQI committee and reviewed by quality assurance team at least quarterly. The facility Administrator and Director of Engineering or appointed team members will monitor compliance.	
K0034 SS=F	Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 Based on observation and interview, the facility failed to provide a continuous protected path of travel to an exit discharge for 3 of 3 exits in accordance with LSC sections 7.2.3.5. LSC 7.2.3.5 requires every smokeproof enclosure shall discharge into a public way, into a yard or court having direct access to a public way, or into an exit passageway. Such exit passageways shall be without openings other than the entrance from the smokeproof enclosure and the door to the outside yard, court, or public way. The exit passageway shall be separated from the remainder of the building by a two hour fire resistance rating. This deficient practice affects all occupants in the	K0034	ADDENDUM ON 7/5/2011THIS PLAN OF CORRECTION FOR K 0034 IS BEING AMENDED TO INCLUDE AN UPDATED FIRE SAFETY EVALUATION SYSTEM (FSES). RTM CONSULTANTS INC, HAVE BEEN CONTACTED AND PLAN AN INITIAL VISIT TO RIVERVIEW HOSPITAL ON 7/11/2011 TO DISCUSS THE A PLAN TO COMPLETE AN UPDATED (FSES) SURVEY. RIVERVIEW RESPECTFULLY REQUEST A 30 DAY EXTENTION IN ORDER TO COMPLETE THIS UPDATED SUREVEY THAT WILL ADDRESS EMERGENCY MOVEMENT ROUTES. TCU NEW DATE OF COMPLETION WOULD BE 8/15/20111.What corrective action(S) will be	08/15/2011

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	facility including residents, staff and visitors. Findings include: Based on observations with the Executive Director during a tour of the facility from 11:30 a.m. to 12:15 p.m. on 06/15/11, the fourth floor on which the TCU is located is divided into two smoke compartments and has three stairwell exits. Additionally, the fire resistance rating of the three exit enclosures on the first floor of the hospital to the exit discharge door is less than two hours. Based on interview at the time of observation, the Executive Director acknowledged each of the three exit discharge passageways are not separated from the remainder of the building by a two hour fire resistance rating. 3.1-19(b)		accomplished for those patients found to have been affected by the deficient practice;This facility does not feel that any patient, staff or visitor had the potential to be negatively affected by this alleged deficient practice because this exit has been assessed by Fire Safety Evaluation System (FSES) which demonstrates equivalent compliance with thier analysis when scoring the total Riverview facility. Please see attached FSES survey and prior Survey conducted by Division of Long Term Care, Indiana State Department of Health regarding K 0034.2. How other patients having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;We do not feel that any patients have the potential to be negatively affected by this alleged deficient practice because we feel that we meet the intent of the law due to the FSES analysis that was completed for this facility. (Safety parameters#10 for Emergency Movement Routes scored deficient (-2) to address this condition)We request a waiver for this requirement based on the FSES which has been accepted by JCAHO and prior Indiana State Department of Health surveys where the facility was found to be in substantial compliance with requirements of participation. (Please note in the attached Life Safety Code Recertification and	

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			State Licensure Survey conducted at this facility by the Division of Long Term Care, Indiana State Department of Health regarding Life Safety K 0034) Survey stated "Correction obviated. Passed FSES" Quality Assurance environmental tours will be conducted at least quarterly at which time this exit will be evaluated to be unobstructed.3. What measures will be put into place or what systemic changes will be makde to ensure tht the deficient practice does not recur;Quality Assurance environmental tours will be conducted at least quarterly at which time this exit will be evaluated to be unobstucted. FSES will reviewed periodically to document changes in the facility. 4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:This corrective action will be monitored through a monthly checlist by a CQI committee and reviewed by quality assurance team at least quarterly. The facility Administrator and Director of Engineering or appointed team members will monitor compliance.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the	K0144	1. What corrective action(s) will be accomplished for those	07/15/2011

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	facility failed to ensure 1 of 3 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. This deficient practice could affect residents, staff and visitors. Findings include: Based on observation with the Executive Director during a tour of the facility from 11:30 a.m. to 12:15 p.m. on 06/15/11, no evidence of a remote shut off device was found for the emergency generator servicing the long term care facility in the hospital. Based on interview at the time of observation, the Executive Director acknowledged there is no remote emergency shut off for the generator. 3.1-19(b)		patients found to have been affected by the deficient practice;No patients were identified as being affected by this alleged deficient practice due to the fact that an emergency generator was available for the TCU that did have a manual stop available for emergencies. Emergency Generator Remote Stop switch will be installed per plan. 2. How other patients having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;We do not believe that any patients have the potential to be negatively affected by this alleged deficient practice because we feel that we were meeting the intent of the law in providing a generator that has the ability to manually be stopped in an emergency. Generator will be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.Consulting Emergency Power Company (Cummins Crosspoint) has been contacted and a plan to install a remote stop has been developed. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Generator will be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.Consulting Emergency Power (Cummins Crosspoint Power	

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			Systems) Company will be utilized to help notify the Hospital on any future NFPA code changes.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;Generator will be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.As part of quality assurance program the remote manual stop switch will be monitored by Riverview Engineering department monthly, during time the generator is exercised under load. Consulting company will utilized to help notify the Hospital on any future NFPA code changes during PM Contraact visits.	